# APPLICATION FOR REGISTRATION AS A SPEECH-LANGUAGE PATHOLOGY AIDE I OR AIDE II

State Form 50322 (R / 2-04)
Approved by State Board of Accounts, 2004

**HEALTH PROFESSIONS BUREAU**
402 West Washington Street, Room W066
Indianapolis, Indiana 46204

***Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

| | |
|---|---|
| **FEE** | |
| **DATE FEE PAID** | |
| **RECEIPT NUMBER** | |
| **REGISTRATION NUMBER** | |
| **DATE ISSUED** | |

**DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY**

***PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.***

Which type of Registration are you applying for? (*check appropriate box*)
☐ **Aide I** ☐ **Aide II**

## APPLICANT INFORMATION

| | | | |
|---|---|---|---|
| Name of applicant (*last, first, middle, maiden*) | | Social Security number* | |
| Address (*number and street or rural route*) | | | |
| City | | State | ZIP code |
| Date of birth | Place of birth (*city and state or country*) | | |
| Telephone number (*daytime*) | E-mail address | | |

## PREVIOUS AIDE REGISTRATION(S) ISSUED

Do you hold or have you held a registration as a speech-language pathology aide? ☐ Yes ☐ No
If yes, list registration number, date issued, date expired and Supervisor's name.

| REGISTRATION NUMBER | ISSUE DATE | EXPIRATION DATE | SUPERVISOR'S NAME |
|---|---|---|---|
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## HIGH SCHOOL, UNDERGRADUATE AND GRADUATE TRAINING

**Please list all levels of education you have attended.**

| NAME OF SCHOOL | LOCATION OF SCHOOL | DATES ATTENDED | DEGREE GRANTED |
|---|---|---|---|
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(*Continued on reverse side*)

| **If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiffs. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following questions is grounds for permanent revocation of a registration issued pursuant to this application.** | |
|---|---|
| 1. Have you ever previously filed an application in the State of Indiana? | ☐ Yes ☐ No |
| 2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? | ☐ Yes ☐ No |
| 3. Have you ever been denied a license, certificate, registration or permit to practice speech-language pathology or audiology or any regulated health occupation in any state *(including Indiana)* or country? | ☐ Yes ☐ No |
| 4. Are you now being, or have you ever been treated for a drug abuse or alcohol problem? | ☐ Yes ☐ No |
| 5. Have you ever been convicted of, pled guilty or *nolo contendre* to:<br>A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?<br>B. Any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* | ☐ Yes ☐ No<br>☐ Yes ☐ No |
| 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? | ☐ Yes ☐ No |
| 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? | ☐ Yes ☐ No |
| 8. Have you ever had a malpractice judgement against you or settled any malpractice action? | ☐ Yes ☐ No |

| **APPLICATION AFFIRMATION** | |
|---|---|
| I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. I am aware of the requirements set forth in 880 IAC 1-2.1 and understand that I may practice as a speech-language pathology aide I or aide II under the direct supervision of the person whose name appears on this application until the expiration of my registration as an aide. | |
| Signature of applicant | Date signed (*month, day, year*) |

# SPEECH-LANGUAGE PATHOLOGY AIDE I OR AIDE II SUPERVISOR'S INFORMATION

## PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS

### SUPERVISOR'S INFORMATION

| Name (*last, first, middle, maiden*) | | Social Security number * |
|---|---|---|
| Indiana license number | | Expiration date |
| Address (*number, street, or Rural Route*) | | |
| City | State | ZIP code |
| Telephone number | E-mail address | |

### NAME OF SPEECH-LANGUAGE PATHOLOGY AIDE I OR AIDE II APPLICANT

| Name (*last, first, middle, maiden*) | Social Security number * |
|---|---|
| | |

### NAME OF HOSPITAL / FACILITY / COMPANY WHERE THE AIDE I OR AIDE II WILL BE EMPLOYED

| Name of Hospital / Facility / Company | | |
|---|---|---|
| Address (*number and street or rural route*) | | |
| City | State | ZIP code |
| Telephone number (*daytime*) | E-mail address | |

**LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER**

### AIDES CURRENTLY REGISTERED UNDER YOUR LICENSE

How many aides are currently registered under your supervision?

Please list the aides name(s) and registration number(s).

| NAME | REGISTRATION NUMBER |
|---|---|
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### SUPERVISION OF THE SPEECH-LANGUAGE PATHOLOGY AIDE I AIDE II

**1. Aide's level of academic training.**

**2. Specify method of supervision.**

**3. Specify training program.**

(*Continued on reverse side*)

| SUPERVISION OF THE SPEECH-LANGUAGE PATHOLOGY AIDE I OR AIDE II (*continued*) |
|---|
| **4. Specify all procedures to be performed by the aide.** |
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| **5. Describe in detail the pertinent educational and work experience for the aide for which authorization is sought.** |
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| APPLICATION AFFIRMATION | |
|---|---|
| I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. I shall be responsible for the direct supervision of the aide for whom this application is submitted in compliance with requirements set forth in IC 25-35.6-1-2(g) and 880 IAC 1-2.1. | |
| Signature of supervisor | Date signed (*month, day, year*) |